DOCUMENT RESUME

ED 067 600 CG 007 541

AUTHOR Mosher, Loren R.; And Others
TITLE Schizophrenia and Crisis Theory.
PUB DATE 72
NOTE 16p.

EDRS PRICE MF-$0.65 HC-$3.29
DESCRIPTORS Behavior Problems; *Crisis Therapy; Institutionalized (Persons); Mental Health; Mental Health Clinics; *Mental Health Programs; *Mental Illness; Psychiatric Aides; Psychopathology; *Psychosis; *Psychotherapy; Rehabilitation; Schizophrenia

ABSTRACT

An experimental two-year treatment project designed to help the acute schizophrenic emerge from psychosis a stronger, better integrated person is underway at Soteria House, a comfortable 16-room house in the San Francisco Bay area. The project will compare the effects of treatment in this special facility with those of "usual" treatment in a community mental health center. At Soteria House, psychosis is viewed as a crisis in development--the organism's attempt to achieve homeostasis in the face of overwhelming stress. Because the psychotic experience is thought to have great potential for natural healing and growth, no attempt is made to abort, rechannel or quell it before it has run its natural course. In keeping with this philosophy, a staff of nonprofessional therapists have been selected for their ability to tune into the patient's crises and have been specially trained to provide reassurance, help in problem solving, support and protection. The treatment approach requires of the staff a tolerance for regression as a sometimes necessary precondition to further psychological growth, as well as prolonged, intensive and intimate contact with patients. (Author/BW)

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

ED 067600

SCHIZOPHRENIA AND CRISIS THEORY Ø

Loren R. Mosher, M.D.*, Alma Menn, A.C.S.W./, Leonard Goveia, M.A.+

I. INTRODUCTION

Although the major tranquilizers have been associated with an improved outlook for schizophrenic patients, 15 years' experience with these agents has shown that they are not curative. Schizophrenia remains our most recalcitrant mental health problem; its scope is reflected in the disappointingly low levels of psychosocial functioning achieved by 65-85 percent of discharged schizophrenic patients, their high readmission rates (about 50 percent within two years) and the relatively large population (more than 200,000) of currently hospitalized patients.[9] In revealing the inadequacies of our present treatment of schizophrenics these figures serve as powerful justification for continued innovation in conceptualization and delivery of services to this population. In part because the ability to deal effectively with crisis defines a successful

---

Ø Presented at the Annual Meeting of American Orthopsychiatry Association, Detroit, Michigan, April 7-10, 1972.

* Chief, Center for Studies of Schizophrenia, National Institute of Mental Health, 5600 Fishers Lane, Rockville, Maryland 20852.

/ Research Associate, Mental Research Institute, 555 Middlefield Road, Palo Alto, California 94301.

+ Research Associate, Mental Research Institute, 555 Middlefield Road, Palo Alto, California 94301.

CG 007 541

FILMED FROM BEST AVAILABLE COPY

person, we have borrowed ideas from crisis theory [1,2,6] in developing a combined research/services program in which the psychotic episode is viewed as a crisis in development with potential for positive growth. By guiding the patient through--rather than repressing--his "altered state of consciousness," our treatment milieu is designed to help him emerge from his life crisis a stronger, better integrated person with the capacity to pursue a life which he himself will view as a success. Because existing treatment facilities are often resistant to change, our project's setting is a house in the community which we have modeled, in many ways, after the Philadelphia Association's (the name given to the group which included R. D. Laing, D. Cooper and others) Kingsley Hall in London. [7]

In this paper we wish to focus principally on our modification of crisis theory for use with psychosis; we will sketch only briefly the research design, setting and staff. Our use of crisis theory in practice will be illustrated by a case example.

II. RESEARCH DESIGN

Basically, the design is a comparative outcome study of two matched cohorts of first-break, unmarried schizophrenic patients between 15 and 40 years of age, deemed in need of hospitalization and followed for two years after discharge. Both experimental and control patients are obtained from a large screening facility (600 new patients a month) which is part of a community mental health center. Patients who meet the research criteria are assigned on a consecutively admitted, space available basis to either the experimental or control group.

The experimental patients are treated in a community facility (described below), and the control patients are admitted to the wards of the community mental health center where they receive "usual" treatment. Both groups are assessed on the same battery of tests which cover a variety of points of view: Psychiatric (diagnosis, type of onset, paranoid/nonparanoid status, symptom pattern), ward and house staff (behavior and improvement ratings), family (perception of behavior and personality characteristics) and self-rating (social and work functioning, attitude toward illness, etc.). They will be followed at six monthly intervals for two years after discharge by means of psychiatric, family, and self-ratings. Data are analyzed by means of an analysis of variance and covariance for change on repeated measures over time. A more detailed presentation of the design is available elsewhere.[8]

III. THE SETTING AND STAFF

Soteria House is a comfortable 16-room house in a transitional neighborhood of a San Francisco Bay area city. The staff has been selected because they seem to have the ability to "tune into" the patient's altered state of consciousness and because they have no theory of schizophrenia into which the patient is to be fitted, procrustean fashion.[10] They have been trained to act as a projective "screen" and mirror for the patients and to provide them with reassurance, help in problem solving, support, and protection. During the acute phase of psychosis, staff members form special one-to-one or two-to-one relationships with the disorganized patient, performing a role similar to that of the "LSD-trip guide"; the psychotic experience is shared and reflected, so long as both patient and "guide" do not experience intolerable levels of fear and anxiety.

The therapeutic dyad is the program's primary interpersonal unit and source of control. Staff members are expected to be in step with, rather than one step ahead of the patients. Authority lines and roles are flexibly defined, depending on the functions to be served (e.g., there are no "staff only" meetings; everyone is expected to help shop for groceries, etc.); staff do not wear uniforms and they are not seen as having "the" answer. There are relatively few prescribed expectations to which residents are pressured to conform; the expectations which are prescribed relate to avoiding harm to the residents, staff, community and program. Much of our program has been designed to minimize rigid role definitions and an associated hierarchical system, both of which we believe make psychological growth more difficult. While the residence encourages patients to participate in a variety of activities (aimed at the development of a sense of self--physical and psychological), their need for solitude and safety in a turmoil is also respected. Because it is meant to develop out of the needs of its residents, Soteria House's program is expected to change as new needs emerge. Our setting costs approximately $25 per patient day, including research. This is slightly less expensive than the average daily cost in California State Hospitals and much less than in the control ward in the local community mental health center, where charges average $100 per day. Of course, the average length of stay in the latter facility is much shorter than is usual in our house in the community. The crucial figure to be considered, however, is the long-term cost of treatment received by an individual patient. Over the long run, we believe our approach will be less costly, given present-day readmission rates, than more conventional forms of treatment and that our

patients will emerge from the psychotic experience less psychologically impaired than those treated in the hospital. Only after two-year followup data are available, however, will we be able to comment meaningfully on this issue.

IV. SCHIZOPHRENIA AND CRISIS THEORY

Basically, we view psychosis as a crisis in the course of an individual's development, which in our selected sample usually first occurs in late adolescence or early adulthood. As with non-psychotic crises (from which most crisis theory has evolved), we view the psychotic crisis state as especially susceptible to change; properly dealt with, this change can be growth enhancing, leaving the individual with a greater sense of integrity, identity and "togetherness" than he had experienced previously. Our orientation is quite in keeping with the definition of crisis given by Thomas in 1909, which contains the explicit notion of positive growth from crisis.[11] In addition, crisis theory has been of value to us in the design and conduct of this project, in part, because of its focus on problem solving, coping, and adaptation. This focus directs greater attention to the potential for growth, development, learning, and education than the traditional medical "disease" model for schizophrenia, which emphasizes "deficits" and "pathology." The crisis focus is also useful for our staff, who are trained to identify the immediate precipitants of the person's coming to psychiatric attention, which in turn helps them to clarify, in a cognitive and affective way, issues which are sources of conflict to the distressed individual. They also relate the precipitants to the individual's social history over time.

An additional important aspect of our project is our tolerance for regression. That is, we expect many of the persons who come to live in our

facility will have periods of intense regression. We believe that, in most instances, this regression is a necessary precondition to further psychological growth. Thus, we have translated traditional crisis theory's emphasis on equilibrium, homeostasis, the organism's "natural healing power" into a tolerance for regression.

Although our study has been underway for less than a year, our experience with the use of crisis theory in this setting has already led us to identify several differences between our approach and that found in the literature on crisis theory and intervention. They are: 1) Our sample is not self-referred; most of these persons are brought to attention because of deviant behavior at home or in the community. 2) We have not always found the source(s) of the crisis which we label "schizophrenia" as easily identifiable as those found in persons traditionally dealt with by crisis theory (e.g., fire victims, new mothers, recent widows, etc.). In fact, in many instances our residents seem to have been for some time in a fluctuating state of crisis and disorganization, with some relatively minor event resulting in their being brought for psychiatric treatment. This seems particularly true for persons whose onset of disorder can be described as insidious. Often, though, the crises' precipitants have been readily identifiable--demands for independent work or academic performance from a child who has usually been assigned the "inept, dependent" role at home, an inability to define a crucial heterosexual relationship, a catastrophic interpersonal event like the loss of an intimate friend, etc. In both types of situations, however, the individual's coping mechanisms are insufficient to deal with the stressful situation. 3) Crisis intervention has generally been confined to relatively short-term treatment on an

outpatient basis. Thus, our study, which is set in a 24-hour care facility, provides more prolonged, intensive, and intimate contact. We have found that the psychotic level of crisis usually necessitates this more extensive and intensive contact than the clearly externally induced crises most often referred to by crisis theory: 4) We believe that our tolerance of, and respect for, regression is greater than that usually associated with crisis theory and intervention. In our reading of crisis theory, the regression which occurs when the individual is unable to cope with a problem seems to be viewed as something which should be dealt with as quickly as possible by the deployment of the person's existing coping skills, or through the development of new ones. It appears to us that much of crisis theory views psychosis as a poor resolution of a crisis. We view psychosis as the organism's expression of crisis as an attempt to achieve homeostasis in the face of overwhelming stress. For us, the depth and pervasiveness of the crises with which we deal means that a longer time will and, perhaps needs to be, spent in a disorganized state. We believe that the inner voyage of the schizophrenic person, which is induced by the environmental crisis, has great potential for natural healing and growth, and we therefore do not attempt to abort, rechannel or quell it before it has run its natural course. But, though our attitude is one of tolerance for regression, we nonetheless expect (and hope) that the person's inner voyage will eventually bring him back toward the outer world. We believe that this voyage will help him integrate the psychotic experience into the continuity of his life, and that he also will be able to come to grips with experiences of growing up which have long been denied, or deliberately kept out of awareness. It is our position that, through the integration

of the psychosis and of these heretofore "split-off" fragments of experience, the schizophrenic person can develop the ability to use coping skills previously unavailable to him and can learn new ones. We also believe that the psychosis can act as the individual's "rite de passage" into adulthood--a ritual which has been noted as lacking in this culture by Erikson[2] and others. From this perspective, too, it may do the individual an injustice to deprive him of the spontaneous psychotic experience.

The context provided by Soteria House is seen as a necessary holding situation for the individual in crisis. The staff are to be respectful, tolerant, empathetic and sensitive to the person's crisis, but they are not to reinforce or perpetuate the regression unnecessarily. Regression is not regarded as an end in itself. The ability to identify the cues given by those who are beginning to emerge from a regression is a delicate clinical skill, but not one which has thus far proved impossible to attain. When recognized, those cues are acknowledged and validated as strongly as the voyage into the depths had been previously. In this way, we hope to avoid unnecessary perpetuation of the regressed state--which can only lead to a career as a mental patient.

Our theory is one of crisis and development, but this does not mean that we believe that every person who is admitted to the house will be in such a state of crisis or that the regressive inner voyage is always necessary to recovery; nor does it mean that we have preconceptions about the reasons for a crisis' occurrence. Rather, we attempt to see each crisis as a unique experience which can nonetheless be shared, understood, and put into perspective. How the crisis evolves and is ultimately resolved should be determined by the patient--not the staff. But we hope our accepting attitude

will help him to take seriously, look at, deal with, come to terms with, and learn from his crisis. We hope too that our presence will make him feel less alone and that he will find comfort in our ability to stand by and support him in his turmoil. It seems to us that the family-like intimacy of the setting is particularly well suited to the development of trust and a willingness to explore the inner self, without fearing punishment for it, or being used to meet the needs of others. In addition, the house makes quite clear that it will meet the individual's needs so long as he is unable to do so himself.

Those who have worked in well-staffed, relatively small, psychiatric hospitals with psychotherapeutic orientations are bound to ask, what does our setting, philosophy and staff add to an ordinary, good psychotherapeutic one? The differences are: 1) A very non-authoritarian, non-hierarchical organization. All staff members are viewed as equal in overall therapeutic potential and their interaction is as a group of peers. Our project director acts as research and referral coordinator, supervisor and mother hen but is not viewed as a "special" therapeutic person. Our part-time psychiatrist evaluates each resident, takes care of medical records, and supervises staff but is not a primary therapist in the house. Although we emphasize the need for schizophrenics to feel "sucessful," we do not mean this in a competitive sense. We want to maximize the possibility of our residents controlling their own destinies, however they wish to define them. In this setting success is defined in strictly individual terms. We believe this view is most congruent with the non-authoritarian, fraternal orientation of the house. 2) Flexibility of response which is difficult to achieve in hospital based care. For example, crisis sessions last as long as necessary, because our staff can and will commonly spend six or even up to 18 hours at a stretch

with an individual resident. In addition, the scheduling of the "therapy" is not based on staff needs and routinely takes place in a variety of settings. 3) Sufficient time and energy to allow the issues to be acknowledged and worked through at the height of intense crisis. The individual in crisis is allowed, encouraged and supported in exploring reasons for whatever "irrational" acts are concomitants of the crisis. They are handled without resorting to such angry rebuffs as "Now, look what you've done" or "What did you think you'd accomplish with that?" 4) The flexible role allocation in our approach to crises. We feel this is both unusual and extremely important in terms of the person's learning to model and imitate behaviors he becomes acquainted with in the setting. 5) The absense of the kind of magical expectations which inevitably are attributed to "the therapist" in ordinary psychotherapeutic settings. At Soteria two or three persons, including other patients, may be seen as therapeutically important, thus diluting any "expert," "fixer" role of an individual. This also seems to lessen the effects of one person's absence, decrease the potential for an over-exclusive shared dependency and make counter-transferance problems less common.

A brief case illustration will serve to illustrate how crises are handled in the house. Marjorie, a 21-year-old, single, ex-Catholic, second oldest of seven, part-time college student, was admitted to the house about a week before the events which will be described below. She had been brought to the local clinic by her roommates when they found her attempting to electrocute herself. A few days previously she had made three deep slashes in her wrists, requiring multiple sutures. On admission she exhibited many signs characteristic of schizophrenia: She was extremely

quiet and withdrawn, showed little or no emotion, had a severe disorder of thought and expressed the firm belief that she was "the devil" and that the TV had been giving her messages to "burn, baby, burn, feel the fire of hell." At 5:00 A.M. one morning the entire house was awakened to the smell of smoke. Marjorie was found sitting quietly in the dining room with her hair burned, frizzeled and matted, with multiple burns in the smock she had worn to bed. She had intentionally lit her mattress on fire with a cigarette and, as it had begun to burn her hair and smock, she changed her mind and went to find a staff member. The fire was quickly extinguished, another mattress was found and another bed made for her. While others were taking care of these details, one staff member sat down with her at the dining room table and began to explore exactly what it was that had happened which made her feel so bad that she wanted to kill herself. She reiterated again and again her feeling of being the "devil" and needing to feel the fires of hell. This staff member spend the next five hours (others also spent less amounts of time) with her exploring in detail recent events which might have resulted in her feeling like such a terrible person. At the time of the fire she looked like a zombie--affectless and motionless. Initially, the events she related were completely disorganized and incomprehensible. They were described with a kind of timelessness, randomness, and contextlessness which made the staff member feel as though he were floating in space or in some vast expanse of ocean. He shared this feeling with her and, as he did so, she seemed to be better able to get a grasp on the events themselves, including very genuine affect. The precipitants of her crisis were the death of a maternal grandfather with whom she was extremely close some six months before, increased difficulties in her relationship with a

sister of whom she'd always been jealous, and a spiraling cycle of sexual promiscuity. The discussion focused on these events, including her wish to have gone to her grandfather's funeral and feeling guilty for not having done so. She had decided not to go because she was afraid she would not be able to deal with her mother and sister and did not want to see her grandmother hurt and crying. Her grandfather had been cremated (she wondered where his ashes had been taken) and this attempt at self-destruction had been her way of joining him. In her relationship with her sister, Marjorie had always been the "bad one," "the irresponsible one" and the loser in the eyes of her mother as compared with her sister. Marjorie had been disturbed by the perverse pleasure she experienced when her favored sister had had to have a hysterectomy one year previously. These two events seemed to be related to her increasing sexual promiscuity, especially the bizarre turn it had taken after her grandfather's death. By mid-morning she was no longer disorganized in her thinking, was affectively very appropriate and even able to smile and laugh occasionally. She cried when speaking of her grandfather's death, was angry with her sister and got very depressed discussing how she felt about her sex life. The change in her face and posture was striking: Her face was appropriately mobile and expressive, and she was able to move about in a very natural way. It seemed that getting in touch with these previously split-off and disavowed events and their associated affects had allowed her to recompensate, at least for a time. The staff member's role was one of support and reassurance (he quite often told her he felt her a worthwhile person), and a gentle guiding of her into herself, to help her identify and clarify the jumbled series of affects and ideas contained within. He tried to stay in her

"space" with her, describing to her how he was experiencing it; by so doing, he validated her feelings and made it clear to her that they were real, comprehensible, and tolerable to him. This last point was made more by his staying with her (and lack of fear in the situation) than any spoken word.

This case illustration, focused principally on a dyadic transaction, does not do sufficient justice to the contribution made by the Soteria context. We also believe that Soteria fulfills the need for group support in crisis noted by Glass and Artiss,[3] Grinker and Spiegel,[4] and Kaplan.[5] For example, the home-like atmosphere (with assurance that someone would bring food when it was time) made it possible for the participants in the situation to continue directing their full attention to the crisis at hand. The lack of built-in distractors (e.g., rounds, charts, meetings, etc., which can be used as excuses to avoid being with people in need) is also notable. The absence of hierarchical structure with its associated role attributions (e.g., "therapist" or "expert") made it easy for several staff people to be involved with Marjorie and allowed the staff person primarily involved in this episode to have only minimal expectations that he alone must "fix" the problem. Thus, as a transacting dyad they had the freedom to explore widely without the limits of the 50-minute hour or the need to do something about what had happened. They shared a block of time and space with few built-in limits. The changes which Marjorie underwent in the five hours described above were remarkable. We view this illustration as evidence for the potential inherent in our approach.

V. Conclusions.

Since our research has only recently begun and involves a two-year-followup period, no outcome data are presently available. Thus, our

approach must still be seen as experimental. In this paper we have attempted to show how we have explicitly extended the universal nature of crisis as a source of change and growth to persons designated schizophrenic. In doing so the similarities and differences between our approach and those which traditionally characterize crisis theory and intervention have come to our attention. These are the primary focus of this communication.

REFERENCES

1. Caplan, G. 1961. Prevention of Mental Disorders in Children. Basic Books, Inc., New York.
2. Erikson, E. H. 1959. Identity and the Life Cycle: International Universities Press, New York.
3. Glass, A. G., and Atriss, J. J. 1961. The current status of army psychiatry. American Journal of Psychiatry. 117:673-683.
4. Grinker, R. R., and Spiegal, J. P. 1945. Men Under Stress. McGraw Hill Book Co., Inc., New York.
5. Kaplan, D. M. 1968. Observations on crisis theory and practice. Social Casework. 49(3):151-155.
6. Lindemann, E. 1944. Symptomatology and management of acute grief. American Journal of Psychiatry. 101:141.
7. Mosher, L. R. In press. Kingsley Hall as experienced by a member of the American establishment. In Kingsley Hall. L. Redler, P. Zeal, and M. Yokum, eds.
8. Mosher, L. R. In press. Research design to evaluate psychosocial treatments of schizophrenia. In Proceedings of the Fourth International Symposium on Psychotherapy of Schizophrenia. Excerpta Medica Foundation, New York.
9. Mosher, L. R., and Feinsilver, D. 1971. Special Report: Schizophrenia. (Publication No. (HSM) 72-9042) U.S. Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, National Institute of Mental Health, Rockville, Md.

10. Mosher, L. R., Reifman, A., Menn, A., and Goveia, L. Indigenous nonprofessionals as primary therapists for acute schizophrenia. To be presented at the annual meeting of the American Psychological Association, Honolulu, Hawaii, 1972.

11. Thomas, W. I. 1909. Source Book for Social Origins. Richard G. Badger, Boston, Mass.